EXHIBIT 8
DATE 3-19-07
SB SB 397

March 19, 2007

To the Chair and Members of the House Human Services Committee:

My name is Rebecca Deschamps. I'm a practicing hospital pharmacist, and I am gravely concerned that SB397 will pose an unacceptable risk to my patients, your constituents, in the state of Montana. As a hospital pharmacist I'm removed from the "sales" aspect of pharmacy, and feel no financial threat from SB397, nor any "turf war" issues. I simply feel concern for the patients that I strive to protect.

I have the greatest respect for Sen. Kim Gillan both as a person and a legislator, and have tried to think of amendments that would address the many patient safety issues that the passage of this bill would open up. Up until now, pharmacies have served among other things as a drug information clearing house. Most of the drugs that a patient is getting from ALL practitioners are listed in the medication profile at their pharmacy. I look at this fact as one last measure of patient safety. While the majority of patients do utilize only one pharmacy, the majority of patients utilize multiple physicians in this era of medical specialties.

I have three main concerns about this bill:

Concern #1: The typical patient uses multiple providers or specialists, and the risk of drug interactions could be therefore by greatly enhanced. Not only does the bill fail to address a mechanism by which the patient's pharmacy could be alerted to new medications dispensed by a practitioner, but no mechanism exists for multiple practitioners to share their dispensing information. Considering the complex drug-drug interactions that exist for most medications today, this is truly an accident waiting to happen. Our patients, your constituents, deserve better. I don't believe that the issue would be quite as ominous if the dispensing practitioner is the primary healthcare provider for the patient. The patient's primary healthcare provider should already have a list of most of the medications the patient is taking. The point at which patients could most likely get into trouble would be when they visit, say, a cardiologist and are put on an anti-arrhythmic, and no other healthcare provider is aware of that fact. If the primary provider made the referral, the cardiologist would most likely send a consult letter to that provider. However if the referring provider is not the primary (say an OB-GYN noticing a strange blip on a routine EKG before surgery) that information might never get back to the primary provider. Serious or fatal drug interactions could result down the road

I recently reviewed the meds of a hospitalized 50-year old male stroke victim. He was unable to communicate well, so I called his primary physician and his pharmacy to get a list of his medications. His physician had him on 3 or 4 different medications including niacin. Niacin is a vasodilator, causing the blood vessels to expand to some degree. When I called his pharmacy to see if he was on other medications as well the pharmacist listed a few items from other practitioners, then said "did anyone mention that he's on Viagra?" Viagra is contraindicated in patients taking nitrates, and nitrates too are vasodilators. The combination can cause profound hypotension (low blood pressure) and among other things, stroke. I reported this back to his primary physician who was grateful for the information even though it was a little late. I'd fault the patient's pharmacy, and possibly the blame still lies there as well, but niacin is also available over the counter. The pharmacy might not have known when they dispensed Viagra that the

patient was taking niacin as well. When the day comes that we have universal medical records, all of this will be a non-issue. Everyone will be able to see the entire picture, rather than just one or two puzzle pieces. However that day is not yet here.

Concern #2: The safety net of patient counseling does not exist in the provisions of this bill. SB397 does not even mandate that written material be given to the patient with regard to their medications. The Montana Legislature considered patient counseling important enough to pass 37-7-406: Standards for prospective drug utilization review and patient counseling:

(1) The board may by rule set standards for the provision of prospective drug utilization review information from a pharmacist to a patient before a prescription is dispensed to the patient or the patient's representative. The review may include, when applicable, an appropriate level of screening for potential drug therapy problems due to therapeutic duplication, drug disease contraindications, drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse or misuse.

The Montana Board of Pharmacy responded by making patient counseling mandatory for all new prescriptions, and at the request of the patient or discretion of the pharmacist for all prescription refills. Even though pharmacists are mandated to offer to counsel on all new prescriptions, and on refills at their discretion, I realize sadly that's not always done. I can't apologize for pharmacists that shirk their duty (to me that would be the most interesting and rewarding facet of retail pharmacy practice), but I do think that most pharmacists generally make that attempt. **Dispensing practitioners shouldn't be held to a lesser standard.**

The question is; will busy physicians and other healthcare providers, who see a new patient on average every 15 minutes, be willing and able to counsel their patients when they dispense medications to them? When I served as Executive Director of the Board of Pharmacy I sent out a quarterly newsletter to pharmacists. In April 2003 I included the following statistics taken from the 2002 Schering Report, conducted by an independent research firm:

* Only 81% of patients are always told by the prescribing practitioner what the drug is for. If not told, they would rarely ask
* Only 67% of patients are always told by the prescribing practitioner how to take a new drug, and 44% are rarely or never told about adverse reactions.
* Forty-nine percent are never given written information about a new drug by their physician or staff. They rarely if ever ask for written information if it has not been offered.

If those supporting SB397 have any expectations that the bill will help patients in any way, those factors must be addressed.

Concern #3: SB397 contains no definition of an employer-based onsite clinic. This potentially opening up the proverbial slippery slope. Why legislate when the intent of that legislation is unclear? Possibly there's a thought that practitioners in clinics are all able to access the same data base and that this fact would help to prevent drug interactions and therapeutic duplication. That would work within each clinic if a central shared database existed, but would not be accessible by practitioners at a second clinic

across town. Again, a central medication profile is a potential life-saver, and an attempt to preserve this would go a long way in protecting our most vulnerable patients. SB397 appears to be a bill requested by an insurance company to save itself money. The fact that it was not requested by a group of pharmacists or physicians sworn to protect the health and safety of their patients speaks volumes to me, as I hope it will to you. The patients we serve and strive to protect on a daily basis are also your constituents. They deserve to be protected by the series of checks and balances presently in place. SB397 would remove those checks and balances, essentially the safety net under our patients, and they simply deserve better.

I urge you to table SB397, or your recommendation of "Do Not Pass" if the bill is sent to the House floor.

Thank you for your consideration.

Sincerely,

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